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PAIN IN THE RIGHT ILIAC FOSSA.*

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Before coming to the subject proper of this evening's lecture, I would like to digress a little, to say a few words on 'pain' in general.

Pain is one of the commonest symptoms of disease and is a symptom of great importance to the practitioners in that it can sometimes be very misleading, while to the patient himself it causes much discomfort.

Pain may be defined as a recognised state of bodily discomfort. The degree of the discomfort varies from person to person It is a protective phenomenon and serving as a danger signal fulfils an invaluable purpose. Individuals vary greatly in their sensitiveness to pain. Some are hypersensitive while others are hypo-sensitive, while in the same person the threshold of pain varies at different times. Some persons minimise the pain that they feel while others tend to exaggerate it. We have at present no instrument by which we could measure or compare the degree of pain that a patient feels.

Pain is due to the excitation of peripheral nerve terminals by noxious stimuli. This may occur in various situations, as for example in the skin, or as muscular cramps, as joint pains in cases of acute arthritis or as the pain felt in malignant tumours of bone. In the viscera no pain is felt unless the serous membrane is involved. In the hollow viscera pain is caused by tension as for *e.g.*, in intestinal or biliary Colic and is due to spasmodic contractions of the tube to overcome the obstruction Pain due to disease of the internal organs may also be felt as a 'referred pain' in the skin, the nerve supply of which corresponds to the spinal segment from which the particular organ is also innervated.

* Read before the South Indian Medical Union, Madras.

Pain in the Right Iliac Fossa can be a source of great anxiety in diagnosis. I may mention in passing that what applies to pain in the Rt. Iliac Fossa applies equally to the Left Iliac Fossa.

Pain in the Rt. Iliac Fossa may be

(1) Acute or

(2) Chronic

Acute pain in the Rt. Iliac Fossa is more easy of diagnosis and is very commonly due to acute Appendicitis and a diagnosis can usually be made from the history. Typically there occurs in these cases a pain, which to begin with is generalised over the whole abdomen and provided the appendix is in its normal position this pain in the course of some 5-6 hours localises itself to the Rt. Iliac Fossa. Other causes of acute pain in the Rt. Iliac Fossa may be Acute Salpingitis, Renal Colic and Acute Tubercular Adenitis.

Chronic Pain in the Rt. Iliac Fossa may on the other hand be very difficult of diagnosis and the Appendix is apt to be too often blamed without justification. We remove the Appendix only to find that the symptoms persist and only by a careful analysis of the problem can we find the correct cause of Chronic pain in the Rt. Iliac Fossa. A correct diagnosis can in most cases be arrived at by a careful study of the history and the physical signs but an elusive case may yet mislead us.

The following is an interesting case in point: " Mrs. A. B. complained of chronic dull pain in the lower abdomen, in the area below the umbilicus and more on the right side. It commenced soon after the birth of her only child three years ago. The pain was relieved by lying down, was referred to the lower part of the Lumbar spine and was sometimes accompanied by nausea. A diagnosis of Chronic Appendicitis was made and the appendix removed. The patient experienced relief for a period, after which the symptoms reappeared." Here it may be mentioned that this temporary relief of pain is quite common in many cases after appendicectomy and is perhaps due to the careful dieting or the rest inevitable to an abdominal section. Where the symptoms have not been due to the appendix they reappear after a time so that we must allow at least 6 months to elapse before concluding that an appendicectomy has relieved the patient. On the other hand an experienced surgeon can on opening an abdomen and seeing an appendix say whether a given appendix is the cause of the pain or not. " Some months later, Mrs. A. B.

returned with a recurrence of her symptoms and following an exploratory Laparatomy the right ovary was removed. Then followed a ventral fixation and subsequently a complete Hysterectomy but the pain recurred. At last some one recollected that persistant chronic pain in the Right Iliac Fossa is sometimes due to disease of the Sacro-Iliac joint and a permanant benefit was obtained by wearing a Sacro-Iliac belt and although there might be something to be said for the method of radical exclusion the patient could have been saved much needless suffering by a correct diagnosis earlier ".

Four points merit consideration with regard to the cause of pain :

(1) The personal equation

(2) The history

(3) The examination of the patient

(4) The interpretation of the data

The most difficult thing of course is to be sure that pain really exists and is constant in situation and character.

Sites of origin of pain :—Pain may originate in areas other than the skin as for *e.g.*, the pain due to pressure on blood-vessels. This is well seen in patients receiving saline intravenously. Here although the vein has been exposed after infiltrating the skin with novocain, the application of an artery forceps over the vein causes pain. Arterial walls are likewise capable of appreciating pain. Subcutaneous-fat is insensitive to pain but the deep fascia and fascial septa are sensitive to pain. Muscle tissue itself is insensitive to pain but the fascial septa between the muscle bellies are sensitive. Periosteum, the viscera and all points along a nerve track are capable of appreciating pain. The skin, deep fascia and inter-muscular septa are all capable of appreciating the prick, temperature and tension. Blood vessels are capable of appreciating tension and chemical stimuli while the hollow viscera respond to undue stretching.

The difficulty in the diagnosis of Chronic Lower Abdominal pain is in some measure due to this area being in anatomical relationship to various structures. These anatomical relationships therefore require consideration.

1. *The Sacro Iliac Joint.*—It is a syn-arthrodial joint. Imperfect fixation of this joint causes oedema of the capsule to occur especially in front

where it is more lax. There is increased tension in the joint causing stimulation of the peripheral nerve endings, the pain being referred to the lower abdomen. There is tenderness when pressure is made over the line of the joint in front. The 3rd, 4th and 5th Lumbar and the upper four Sacral nerves are also in relation with the joint in front. The points of exit of these nerves are bony foramina which are not wide enough so that were exudation to occur over the front of the joint the nerves are pressed upon and this causes both local and referred pain over the Rt. (or left) Iliac Fossa.

2. *The Psoas muscle* also overlies the joint and the lumbar and sacral nerves. Should it get inflamed and oedematous, tenderness and pain are noted over the corresponding Iliac Fossa.

3. *The viscera* in relationship to the fosse are the commonest source of pain in this situation. This pain may be felt *locally* over the site of the affected organ or may be a *referred* pain when it is felt in a situation remote from the area primarily involved.

The viscera concerned are:

(*a*) The lower few inches of the Ileum.

(*b*) The vermiform appendix.

(*c*) The Fallopian Tube (Rt).

(*d*) The Rt. ovary.

(*e*) The caecum.

(*f*) The ascending colon.

(*g*) The Ureter.

(*h*) The Kidney.

(*i*) The Lymph Glands situated at the ileocaecal angle and retroperitoneally behind the iliac vessels. The spinal segmental innervation of the area involved is from the 10th Dorsal to the 3rd Lumbar Segments.

We shall now give a closer consideration to the individual causes of pain in the Rt. Iliac Fossa.

I. *Chronic Appendicitis.* The popular conception that Chronic Appendicitis is wholly responsible for pain in the Rt. Iliac Fossa is only half true. It may be stated straightway that if this pain arises wholly in the

Rt. Iliac Fossa and persists in that position, it is certainly not due to appendicitis. When appendicitis develops three processes are concerned in the production and distribution of the pain. These are in the order of their occurance;

(1) Severe spasmodic contractions of the lower coils of the ileum, the caecum, the pylorus and the appendix.

(2) increased tension of the appendix.

(3) infection of the peritoneum.

The first of these processes causes the pain to be referred to the midline of the body especially the supra-and infra-umbilical regions. The second process causes the pain to be referred along the course of the 10th and 11th Dorsal nerves on the right side which is felt in the subumbilical area on the right side. The 3rd and last process of localised peritonitis results in tenderness especially at McBurney's point, if the appendix is in its normal position which occurs in about 85 per cent of cases. The sequence of events is thus, pain at first in the epigastric, umbilical and sub-umbilical regions; later localising in the Rt. Iliac Fossa. In the 15 per cent of cases where the appendix is not in its normal position as when it is situated underneath the liver due to an imperfect descent of the cæcum, it is situated in the retrocæcel pouch or is in the pelvis no tenderness is felt in the Rt. Iliac Fossa.

II. In another type of case with pain in the Rt. Iliac Fossa the attacks of pain are intermittent and occur at different times of the day. They have no relation to the ingestion of food and nausea may be present. The appetite is indifferent and there is obstinate constipation. The patient is a nervous individual with thin abdominal walls. On examination no local rigidity can be felt but there is a sensation of discomfort especially on deep palpation. The pain is relieved by lying down. The point of maximum discomfort is a little below and on the inner side of McBurney's point and gurgling of the cæcum is also felt. X-ray examination reveals some degree of stasis in the cæcum and in the commencement of the ascending colon. Only too often is such a case diagnosed as chronic appendicitis and an appendicectomy performed but without any subsequent relief to the patient. The pain in this type of case is due to a spasm of the lower coils of the ileum, the cæcum and the ileo-cæcal valve. Some people appear to be peculiarly subject to unusual spasm at certain junctional parts of the alimentary tract. These are, the pyloric junction, the ilea-cæcal junction, the so called midcolic junction and the pelvi-rectal junction and in some persons increased spasm occurs at these

situations. It should also be remembered that in about 50 per cent of individuals the cæcum has a meso-colon which allows a certain amount of mobility of the organ.

We do not yet understand why this increased spasm with consequent pain, occurs in certain cases. Although these cases may superficially suggest that something is wrong with the appendix, the sequence of events, the distribution of pain and the absence of rigidity should enable us to refrain from pointing the accusing finger at the appendix.

III. *The tubes and the ovaries* are a common cause of confusion. This is partly because the area of the referred pain is similar to that of the appendix. Ovarian pain is referred along the 10th dorsal and Tubal pain along the 11th dorsal nerves. The point of maximum tenderness is, however, at the internal abdominal ring *i.e.*, internal to and below McBurney's point. This is due to the fact that the infundibulo-pelvic ligament is attached to the anterior abdominal wall at the site of the Int. Abdominal Ring.

IV. *The kidneys and Ureters.* In a certain number of cases of Renal colic, the patient complains of pain in the Iliac Fossa. More typically the pain is felt in the loin and shoots down to the groin. Cases of Pyelo-nephritis may also have referred pain in the Rt. Iliac Fossa. A kidney with increasing tension distributes the pain to the Iliac Fossa through the ilio-hypogastric and ilio-inguinal nerves.

The lower part of the *Ureter* being in close relation to the Rt. Iliac Fossa, pain may be felt in this situation in diseases of the ureter. Recurrent attacks of pain are especially liable in cases of stricture of the lower end of the Ureter the pain being referred to the sub-umbilical region. In these cases tenderness can be elicited on the inner side of the Iliac Fossa.

V. *The Mesenteric Glands* may become inflamed and cause pain with an associated intestinal catarrh and diarrhoea. The inflamed glands are very tender but there is no absolute rigidity as such. Such cases are very difficult to diagnose and only a laparotomy can sometimes decide the issue.

VI. *The Psoas Muscle* as already stated may be the cause of Iliac pain. This is especially likely to occur due to the stretching of the muscle as after forcible manipulation of the hip-joint.

VII. *In Osteo-arthritis* of the spine, pain may be felt along the course of the Lumbar and Sacral nerves due to the pressure of the osteophytic

growths on the nerves at the points of their emergence through the comparitively narrow intervertebral foramina. These cases are commonly diagnosed as appendicitis but a careful examination will reveal that the pain is worse at night while the X-ray may show osteophytes at the intervertebral foramina.

VIII. *Lesions of the Sacro-iliac joints* causing pain in the Iliac Fossa has already been referred to.

IX. Another cause of pain in the Rt. Iliac Fossa is that due to peritoneal and fascial stretching caused by an *incipient Inguinal Hernia* which just while passing through the inguinal canal has got to stretch its boundaries with resulting pain.

The above are the chief causes of pain in the Rt. Iliac Fossa. A recollection of them and a logical analysis of all the available signs and symptoms is of importance in the accurate diagnosis of pain in the Rt. Iliac Fossa.

POST-GRADUATE MEDICAL EDUCATION IN MADRAS.

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Gentlemen,

With your kind indulgence, I want to say a few words on what I consider to be very important, from the point of view of the future of post-graduate medical education, which must have repercussions on the standard of public health and medical relief. A group of highly cultured individuals should certainly set up the standard of medical practice and the standard of public health. We know that our qualifying degrees and diplomas are just an introduction to a life-long study of men and their diseases. Though the majority of us are bound to become general practitioners, a minority should necessarily take up specialities to be proficient in everything of something. The general practitioner has certainly a wider perspective on human ailments than a specialist. Even the specialist would be well advised to have some years of general practice before narrowing himself to the speciality.

Even the general practitioner must necessarily have revision courses to keep himself abreast of the modern tendencies and developments in medicine. For this purpose there must be an efficient system of post-graduate teaching and education, in which the specialists should take a leading part. And how are we going to train and create specialists? Can we afford to sit silent over this?

The Present Position.

The present position of post-graduate medical education, is, in my opinion, very unsatisfactory. Except for a few higher degrees like M. D., M. S., D. G. O. and B. S. Sc., there is nothing to boast of. The regulations for the M. D. and M. S. were framed more than a quarter of a century ago and if they have to serve any higher purposes they must be thoroughly remodelled to suit modern conditions. It is because we, post-graduates, were sitting silent all these years the authorities have been sleeping over it. We

have a stake in the future of the medical education and medical relief and our voice must be heard. A higher standard of teaching and coaching will certainly create a higher standard of medical practice. It is an irony of fate that we have not yet evolved a self sufficient system of post-graduate education comparable to those obtained in foreign countries. How long are we to depend on an expensive travel to foreign lands to get higher diplomas in medicine, surgery and other specialities? Though many of us obtain theoretical knowledge on the subjects and exhaust the limited English alphabet in the suffixes added to our name, very few only have opportunities of learning the technique. I make bold to say that we learn the A, B, C of technique in our practice here, though we pay and spend heavily on foreign diplomas. The time must soon come when we should be self-reliant and if at all we go to foreign lands we should go to obtain specific training under world teachers of medicine and in the leading centres of research. I can understand any of us spending his money and State money to work under men like Dr. Bohler, Sauerbuech, the late Lord Moynihan, the late Sir Robert Jones, Harvey Cushing, the late Frazier, Thomson Walker, H. Young, etc., (I am afraid I have come across only surgical giants), but I cannot understand the mentality behind us, spending our money to get a diploma like F. R. C. S., and M. R. C. P., and even lower degrees and diplomas, without any claim to additional technical skill. I know that the market value attached to such diplomas induces us to do such a thing. The remedy is in our hands. We shall by our honest work here as post-graduates improve the status of post-graduate medical education to such a height and standard that the authorities will be reluctant to spend any more on foreign diplomas, without reference to the acquirement of special technical skill in special branches of medicine and surgery. We can rather spend heavily on few of us getting first class proficiency in special branches, than spending on several of us just to obtain a higher diploma. Those few who return should be centres of the spread of medical and surgical enlightenment and should be the accredited leaders, not to monopolise and corner all the practice in the specialities, but to train future leaders and specialists. Such real leadership should eventually obviate costly exodus to foreign lands. Can we not take an example from Tagore's Visvabharathi? When India leads in philosophy and is trying to lead even in physical sciences, can we not bestir ourselves to lead in medicine also? The Calcutta School of Tropical Medicine is the latest example of India attempting to take the leadership. In justice to this train of my thoughts I must say that the primary fellowship examination in Anatomy and Physiology conducted in Indian centres is cutting at the root of the development of Indian post-graduate medical education.

Our Materials.

As regards the wealth of clinical materials, Madras, at any rate, is unrivalled. Talking about buccal cancer an English Surgeon recently remarked, " Nowhere in the whole world is there such wealth and variety of cases." A distinguished English Ophthalmic Surgeon in a recent professional interview on a case of leucoma of the cornea requiring Keratoplasty remarked, " We, in Madras, have far greater experience of Keratoplasty than any English, Continental or American Surgeon, because of the immense wealth of cases with hopeless leucomata." These two typical unbiassed statements must open our eyes and remove our inferiority complex. We are lacking in two things (1) publicity of our work, (2) research spirit on our part. These two things we should try to rectify if we want to lead in medicine.

How to improve post-graduate education ?

As I have mentioned before, the regulations for the M. D. and M. S. were framed more than a quarter of a centrry ago. The following, in my opinion, are the defects of the existing M. D. regulations :

(1) The examinations for the M. D. and M. S. are held only once a year. It is a great hardship for those who fail. They have to wait for twelve additional months, with the ever recurrent risk of failing. It is well known that before a person attains his M. D. or M. S. in the University he can get a host of foreign diplomas, if he has enough money or if he is lucky to get study leave. For this putting a premium on foreign diplomas, the University regulation alone is responsible. It is but just that the M. D. and M. S. Examinations as well as the others that I am going to mention, must be held at least *twice* a year. The study may be continuous and there is greater chance of passing in a second attempt. At the time when the regulations were framed the Intermediate and all the examinations were held only once a year. Even Medical Examinations were held only once a year. The University must move with the times and we must agitate till we attain our object.

(2) There are four branches in medicine. Some additional branches, such as Public Health, Anatomy, Physiology, Bacteriology, etc., may be added.

(3) The first general paper in medicine may conveniently be abolished for branches II and III. It is needless for branch II and quite out of place

in an Examination for Pathology. The syllabus in Pathology must be more defined and must comprise purely pathology and bacteriological principles and not bacteriological technique. As I have mentioned before, Bacteriology must form a separate and independent branch for the M. D.

(4) Provision must be made for exempting candidates from written examination in M. D or M. S. if a thesis based on original work is approved by the Board of Examiners. And also candidates must be exempted from written examinations on a second or subsequent appearances, if in the opinion of the Board of Examineres, they did satisfactorily on their previous appearance. Such regulations are in force for the Bombay M D. and M. S. Examinations.

(5) The regulations for the M. S. Examination may be revised to include the following branches (1) General Surgery (2) Orthopaedic surgery (3) Oto-Rhino-Laryngology (4) Urology, (5) Ophthalmology, etc. For branches 1 to 4 there may be a common general paper on Surgery with two other papers in all the branches. The Clinical and Oral examinations should be confined to the specialities only in branches 2 to 5. For ophthalmology there need be no paper on general surgery.

(6) Any holder of the L. M. S. Degree of not less than five years' standing provided he has got M. B. Marks in Pathology, Medicine, Surgery, and Midwifery only, originally or at subsequent appearances, must be deemed to have qualified for the M.B.B.S. Degree and permitted to sit for the M. D. and M. S. Examinations. It is needless and irksome to ask him to pass in Physics, Chemistry, Biology, Anatomy etc. The regulations must be elastic and not " wooden, stony and antedeluvian ".

(7) The University can create new diplomas in Ophthalmology, Dental Surgery, Bacteriology, Oto-Rhino-Laryngology, medical laboratory technique, psychological medicine, anaesthesia, radiology, venereology, tuberculosis, dermatology, etc.

How to attain these objects.

To attain these objects the need for a strong Medical Postgraduates' Association is very urgent. The present assembly itself can form the nucleus and may appoint a committee of five to draft rules and regulations to be submitted to a meeting of the general body to be convened at an early date.

Conclusion.

In conclusion may I also suggest to you to think of the idea of forming colleges of physicians and surgeons separately on an All-India basis like that obtaining in America and Australia. These colleges of which the fellows may be styled F. I. C. P. and F. I. C. S respectively must be started with a view to improve medical and surgical sciences and not to give licences to practice. The licence to practice must be conferred by the Universities only. The L. M. P. may safely be abolished for good.

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PRIVATE PRACTICE AND SERVICES.

There has been an insistent demand from the public and from the profession for a long time that the Services should be prevented from engaging in private practice. From time to time various and conflicting reasons have been given by the Government and its spokesmen against this reform. A few years ago it looked as if the Government had recognised that in the interest of the public and of the practitioners this privelege of practice should be restricted. They said that they were waiting for the time when there would be a sufficient number of practitioners available to the public. But it is now given out that by preventing service men from practising, the public would be denied the advantage of getting the services of efficient medical men. It is again being alleged that the services contain the cream of the profession. We thought that this view had been exploded long ago but we are surprised that it is again seriously put forward by responsible and intelligent people. This theory of the cream is not tenable. A little scrutiny of the figures available for the last few years will easily convince people of the error of this argument.

Before the advent of the Great War in 1914 competitive examinations were held to recruit for the provincial service. Practically everybody who sat for the examination was appointed to the service. The competitive examination was meant for the selection of the individuals, but in practice, it was only for the purpose of arranging the *order* of the people appointed. Therefore to say that the service recruited up to then contained the cream of the profession is far from the truth. The Provincial Medical Service included almost everybody who desired a place in the service. After 1914 up to about 1925 or a little later there was no competitive examination and people were

selected to this service not because of academic distinction or meritorious professional work but mostly because of their services in the army. After the lapse of a number of years, the competitive examination was revived and it was working for a few years. In one year about 42 people sat for the examination of whom 26 were selected. 13 or 14 were appointed, the rest of them did not get into the service because recruitment ceased on account of retrenchment. We wish to know whether the Government maintain that those that were selected were the first and most brilliant of the lot, apart from considerations of communal representation in the service. In the year previous to that everybody who sat for the examination was appointed. A little previously some of the best among the batch of the Medical Graduates sought service in the Public Health Department and not in the Medical Department. There is no need to labour the point. An impartial and reasonable survey of the method of appointment and the men appointed would prove our contention that the services do not monopolise the cream. It is well known that during all these years some of the best men kept out of service. People entered service not because they were brilliant, but often because they could not afford the money to start on private practice. It is commonplace that brilliant academic career does not always or often imply efficient professional attainment in later years. Therefore to hold on to the theory that the service contains the best men and their services should be the best available for the public is to put it mildly a little unreasonable.

There has recently been an advertisement calling for applications from Medical graduates for the posts of assistant surgeons in the Madras Medical Service. If the Government is earnest about helping the formation of a strong and healthy medical profession and if it is convinced that the privilege of private practice stands in the way of service medical men giving of their best to public service the Government should take this opportunity when fresh appointments are being made so to modify the rules of service that the privilege of private practice is not automatically guaranteed.

GLEANINGS FROM MEDICAL LITERATURE.

8. THE EFFECT OF THE REMOVAL OF THE PATELLA FOR SIMPLE TRANSVERSE FRACTURES ON THE FUNCTION OF THE KNEE JOINT.

R. BROOK, F.R.C.S.

Proceedings of the Royal Society of Medicine, January 1937, pages 203 et seq.

Deliberate removal of the patella as the method of choice in transverse fractures of the patella is described with case histories of ten cases so treated.

The affected limb is tightly bandaged in wool at the time of the accident and after 48 hours' skin preparation and usually within five days of the accident, the operation is performed under general anæsthesia.

A tight tourniquet is applied and through a 3″ vertical incision over the patella all blood clot and debris are removed and the two halves of the bone shelled out. The gap in the quadriceps tendon so created is repaired with fascial strips and the torn lateral expansions carefully sutured. Dressings are applied over 2 lbs. of white wool in the form of a bandage.

On the second to the fifth day the patient is allowed to walk with the knee extended, by grasping the backs of two chairs and after the fifth day without their aid. On the seventh day flexion of the knee is allowed within the limits of the bandage. On the tenth day the sutures are removed and a rubber knee bandage is applied which is worn day and night for two weeks and by day only for a further two weeks. The patient is allowed to return to work in from 3-6 weeks after the date of the operation depending on the nature of his occupation.

Tests made to measure any loss of strength in the quadriceps on the side operated upon proved that in fractures of the patella treated by simple excision of the fragments the resulting limb is not only functionally superior to the limbs in which the fracture was treated in other ways, but also that such a limb was functionally equal to and in many csses even superior to the limb on the affected side.

M. K.

9. LECTURE ON FAINTS AND FITS.

A. Rae GILCHRIST,

B. M. J., 30th January 1937, P. 203.

The terms 'faint' and 'fit' are difficult of definition. Convulsive movements and loss of consciousness occur in both and the degree to which either of these symptoms dominate the clinical picture varies widely in both 'faints' and 'fits'. The present discussion is limited to attacks characterised by sudden and transient weakness, loss of muscular control, a greater or less degree of amnesia if not actual unconsciousness with or without convulsive movements.

Three Clinical groups can be recognised.

i. *Seizures* due to disturbance of the *autonamic nervous system.*

ii. *Syncope* the result of an intrinsic disturbance of the heart beat causing *cerebral ischaemia.*

iii. *Seizures* directly of cerebral origin and due to local structural and metabolic defects.

Group I in which there is a disturbance of the balance between heart rate and blood-pressure. This may occur under a variety of circumstances as the erect posture, long hours without food, in convalescence after debilitating illnesses, hot stiffy rooms or exposure to cold and damp. The emotional tone of the patient at the moment plays an importaut part in the precipitation of the attack. Evidence is also available that a certain group of people are liable to fainting attacks due to a peculiar sensitivity of the carotid sinus to mechanical pressure in the neck, while *postural hypotension* is a peculiar and characteristic fainting indicating a more or less permanent disorder of the autonamic nervous system.

Group II. The outstanding example of syncope of cardiac origin is the *Stokes Adam seizure.*

Others are :

(1) Transient paralysis of ventricular activity due to intermittant complete Block.

(2) *Paroxysmal Tachycardia.*

(3) After *Coronary Thrombosis* when followed by an acute fall of B.P.

(4) *Valvular lesions* are rarely associated with syncope and of the valvular defects aortic stenosis rather regurgitation is the commonest form associated with syncope.

(5) Syncope occasionally accompanies the *angina of effort*.

Group III including

(1) *Major and Minor epilepsy*,

(2) The fits of *eclampsia, lead-poisoning and glomerulo nephritis* attributable to local vasoconstruction with high B.P.

(3) Epilepsy of symptomatic origin; most often the result of *Cerebral Tumour*.

(4) *Neurosyphilis* and *hypertension* with vascular disease,

(5) Epilepsy following penetrating *wounds of the dura* which may occur even after several years,

(6) *Cysticercosis*.

In the *epileptic borderland* is the syndrome termed by Gowers the *vasovagal attack*.' It arises abruptly often after a prolonged period of mental strain or anxiety and may last from 10 minutes to half an hour. The most striking, urgent and dreaded symptom is the sensation of impending death although the attacks are never fatal.

Sedative drugs such as luminal do much in diminishing the frequency of these attacks. True idiopathic epilepsy has been known to follow several years after the first of these 'vaso-medullary seizures.' This sequence is, however, exceptional.

M. K.

10. THE BÖHLER CLAVICULAR SPLINT IN THE TREATMENT OF CLAVICULAR INJURIES.

A. H. TRYNIN

The Journal of Bone and Joint Surgery, April 1937, Pp 417 et seq.

The use of the Böhler clavicular splint for the treatment of fractures of the clavice is described.

The most common seat of fracture is at the junction of the middle and outer thirds of the bone, the inner fragment being drawn upwards while the outer tends to be drawn forwards downwards and towards the sternum. Most methods of treatment employed attempt to elevate and retract the shoulder to effect alignment and no serious attempt is made to depress the inner fragment. This results in over-riding of the fragments and deformity at the site of fracture.

To effect reduction it is necessary to raise the outer fragment, to correct the shortening by traction away from the chest and most important, *depress the inner fragment.* This is best done by standing behind the patient, by placing the clenched fist in the axilla by raising the shoulder and by pressing the elbow towards the patient's body. The inner fragment is then pressed down. This position is maintained by the application of the Böhler Clavicular splint. Briefly the splint consists of a tapering light board with upper wider and concave end covered with felt to fit the axillary curve. Two malleable ribbons fasten the board to the trunk. A third ribbon fixed to the splint goes over the well shoulder and serves to raise the splint and with it the injured shoulder. A fourth belt with buckle is introduced under the lower of the two trunk ribbons and serves to press down the inner fragment. This is the most important feature of the apparatus. All parts are well padded and a small piece of felt is placed over the portion of the clavicle that is to be depressed.

Once reduced the fragments remain reduced and the only care required is to tighten the buckle of the belt going over the injured shoulder in order to increase the pressure when needed. The extremity is free at all times and one need fear no stiffness of shoulder or elbow or atrophy of the muscles. The patient is ambulatory and requires no hospitalisation.

This form of treatment should not be used in fractures of the inner half of the bone as it is not possible to maintain the pressure over the inner half, especially if the neck is short and thick. The webbing will slip over to the outer fragment and may only serve to increase the deformity.

M. K.

11. A NEW TREATMENT FOR CHRONIC LEUCORRHOEA.

Alec BOURNE, L.T. Bond and Mc GARRITY,

B. M. J., 16th January 1937, P. 116.

Whether the excessive mucus secretion is due to chronic inflammation of the cervical glands or due to an endocrine disturbance, the only certain

method of stopping the discharge, at present available, appears to be destruction of the whole of the mucus membrane of the cervical canal. The application of chemicals is of uncertain action while the application of the diathermy cutting curette or the electro-cautery not only makes an anæsthetic imperative but may also cause serious hæmorrhage.

The authors advocate the use of porous clay pencils—made in 4 sizes 1⅛" long and of varying diameters. They are placed in a saturated solution of zinc chloride for 10 minutes and a suitable size usually No. 3—¼" thick is inserted without pain, into the cervix. Removal is easy by a wire inserted into the proximal end of the pencil. The aim is to produce necrosis of the mucosa to a depth of 2—4. m.m. It is important that the entire pencil is inside and no part projects beyond the OS and a gauze soaked in Soda Bicarb solution to neutralise any leakage of the Zinc Chloride is loosely packed against the cervix and helps to keep the pencil in situ. No. 4 pencil is put for 2 hours, No. 3 for 3 hours and No. 2 for 4 hours after which the pack and the pencil are removed and no further treatment is necessary. During the 2nd to the 4th day after the treatment discharge is absent and thereafter for some 3 weeks a profuse seropurulent discharge occurs which gradually stops leaving only the normal moisture of the vagina. A slough of the cervical mucosa is produced and discharged in about a week.

Thereafter a complete re-epithelialisation of the canal occurs and has been demonstrated in sections taken after varying intervals.

M. K.

NOTES ON PREPARATION.

GLUCOSE A. D. recently introduced by the well known firm of COW & GATE LIMITED seems to be an improved form of this valuable carbohydrate food. The role of glucose in dietary and certain metabolic disturbances is now of course well established. In the new Glucose both Vitamins A and D are present, and it is emphasised that they are derived from natural sources only. Glucose A. D. also contains 2 per cent glycerophosphate, thus adding to its value in the treatment of calcium deficiency.

MEDICAL COUNCILS.

MADRAS MEDICAL COUNCIL.

The Madras Medical Council resolves to inform all Registered Medical Practitioners to conform to paragraph 24 of the Code of Medical Ethics, as published by the Council. Whenever they are asked in a Court of Law to divulge professional secrets, they should first of all claim privilege, not to divulge the same, and, if this is overruled by the Court, get this claim recorded and then answer the questions under the express direction of the Presiding Judge or Magistrate.

(By Order of the Madras Medical Council)

ELECTION TO THE BOMBAY MEDICAL COUNCIL.

We have received an appeal signed by representative and influential group of medical men of Bombay supporting the candidature of Dr U. B. Narayana Rao, for one of the two seats to be filled in the Bombay Medical Council by the non-graduate Constituency.

Dr. U. B. Narayana Rao has been the General Secretary of the All-India Medical Licenciates Association since 1933 and is the Editor of the 'Medical Digest' and the Indian Journal of Venereal Diseases. As a senior practitioner of a very wide and liberal outlook we feel confident that, if returned, it will be his constant endeavour to safeguard the interests of the private medical practitioner.

MADRAS

REVIEWS.

VADE MECUM OF MEDICAL TREATMENT.

By

W. GORDON SEARS, M D. (LOND.) M R.C.P. (LOND.)

Deputy Medical Superintendent St. Charles's Hospital, London.

1937 Pp. 368. Bound in Leather cloth Price 10/6 net. Edward Arnold and Co., London.

The author has given in this book in a concise form an account of treatment of common conditions met with in General Practice. Disease conditions are arranged alphabetically and notes of appropriate treatment given under each heading, an arrangement that would help an easy and a quick reference. The notes on treatment have been selected and such of those measures that have given good results under the hands of the author or his Colleagues have been given, while proprietory products like prontosil as a remedy for erysipelas, Sodium mandelate for pyelitis, Ascorbic acid for scurvy have been included.

Posological tables and other useful information are given at the end of the book—a good and carefully prepared index ends the book. The book is handy and printing good. It is strongly bound in leather to stand constant use. The book should prove useful as a ready reference in one's practice.

KING GEORGE MEDICAL COLLEGE CLINICAL SOCIETY JOURNAL.

Vol. xx. Silver Jubilee Number. No. 2. February. 1937.

The Silver Jubilee of the King George Medical College, Lucknow was celebrated on January 30th 1937 and in commemmoration of the Jubilee the clinical society has issued a special number containing a record of progress of the institution during twenty five years.

The Editorial gives in brief a survey of the twenty five years progress and one learns with interest how the institution was started in the year

1906—in the words of the Editor " In the days when the world was happy and prosperous. Its infancy saw the greatest world war in history. Its childhood watched the steady progress of the science of Medicine in a troubled world. It passed its youth during the economic depression which followed the prosperous times after the war, and today we enjoy its Silver Jubilee and look back with satisfaction and pride at twenty five years of continuous progress in medical education."

This number contains many messages of congratulations including those from Major-General Sir J. W. D. Megaw, Major General Sir C. A. Sprawson and others. Every department of the medical college hospital has contributed its own progress during the past twenty five years—many of them illustrated. Besides these there are three original articles, one by Capt. R. D. Alexander M. R. C. P., I. M. S, 'Medicine in Renaisscence,' one by Mr. S. N. Mathur F. R. C. S., on the Progress of Surgery in the past 25 years and one on Advances in Medicine and Therapeutics during the last 25 years by Dr. B. B. Bhatia, M. D. M. R. C. P.

The printing is good and the cover is best suited to the occasion blue print on a background of silver art paper. We wish our contemporary many more years of useful service and continued prosperity.

THE ANTISEPTIC VOL. 34. No. 2.

February 1937, Special Number in Tropical Diseases.

EDITED BY DR. U. RAMA RAU & DR. U. KRISHNA RAU, PRICE RS 2.

The Antiseptic had, since 1929, made a welcome departure in publishing special issues on the various branches of medical science—such as Ophthalmology, Radiology, Obstetrics and Gynaecology, Venereal Diseases, Pediatrics etc., and the latest publication, which we are now reviewing, relates to Tropical Diseases. Speciality is the cry of the hour and the general Practitioner, especially in remote rural parts is handicapped in various ways in getting himself posted with up-to date knowledge of these special branches of the medical science and to him these special issues are a real boon. The Tropical Diseases Number contains useful information for the General Practitioner with regard to the diagnosis and treatment of diseases which he commonly meets. The contributions are both interesting and instructive and the get-up is nice. We congratulate the Editors on the success of their new venture and wish the journal many more years of useful service to the Profession.

V. C. S.

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ASSOCIATION NOTES.

INDEPENDENT MEDICAL PRACTITIONER'S ASSOCIATION, TINNEVELLY.

The inaugural address of the Independent Medical Practitioners' Association, Tinnevelly, was delivered on 10th April' 37 by Dr. T. N. Govinda Aiyar, a senior practitioner of the place, on the subject of the "Art of Private Practice."

In the course of his lecture, he said that only those with registerable qualifications should be permitted to practise. He said that both the general and special practitioners must have a thorough equipment. Referring to the general practitioner, he said that he must have, besides the thermometer and stethoscope, the blood-pressure instrument, a microscope, auroscope and Ophthalmoscope The specialists also must have complete equipment in their line. Dealing with the relationship to fellow doctors, Dr. Govinda Aiyar said that the rules of medical etiquette should be strictly followed. Consultants should remain as consultants only and not encroach on the field of general practitioners. Proceeding, the speaker said that the practitioners should exercise great care in their relationship with patients, to whom they must show great consideration and friendly and sympathetic attention. Patients must be attended to at all times. Every practitioner must have a settled scale of fees for all, though concessions could be shown to poor people.

With a vote of thanks to the speaker, the meeting terminated.

SOUTH CANARA DISTRICT MEDICAL ASSOCIATION.

The meeting of the South Canara District Medical Association was held at Mangalore on the 17th April '37 at the Government Headquarters Hospital under the presidency of Dr. Nambiar, District Medical Officer, when Dr. Umesha Rao of Moolky, who has just returned after an extensive training in the treatment of tuberculosis spoke on tuberculosis and its treatment.

Dr. Umesha Rao said that due to the strain of work in the big cities tuberculosis was on the increase in India. Though the principles of modern treatment of the disease was not much different from the old ones the application of modern science had made it possible to control the disease. He then described in detail the anti-tuberculosis work that was being done by the Bengal Tuberculosis Association and hoped that similar associations in this district will also be formed.

Dr. Kini then gave some of his experiences of Artificial Pneumo Thorax treatment.

TRICHINOPOLY DISTRICT MEDICAL ASSOCIATION.

The monthly meeting of the Trichy District Medical Association was held on 24 April '37 at the E. R. High School, Teppakulam, with Dr. Norman, Chief Medical Officer, South Indian Railway, and President of the Association, in the chair.

Dr. P. Rama Rao D.M.R. (Vienna), delivered an interesting lecture on "Radiotherapy of Tumours" which was followedby a discussion. A committee of hosts gave tea and dinner in honour of the recent Honours bestowed on Dr. (Mrs) D'Costa, who received a Kaiser-i-Hind Medal and Rao Sahib A. Mathuram.

TUTICORIN MEDICAL UNION.

The monthly meeting of the Tuticorin Medical Union was held on 29th April' 37 in the Government Hospital premises under the presidency of Dr. K. S. Iyengar L. M. & S. Civil Surgeon and President of the Union. The President was 'at home' to the members of the Union. Dr. P. Raghavendra Acharya delivered an interesting lecture on "Blood Pressure". A discussion followed among the members about the practical difficulties experienced with cases treated by them. After a few concluding remarks from the chair, the meeting came to a close.

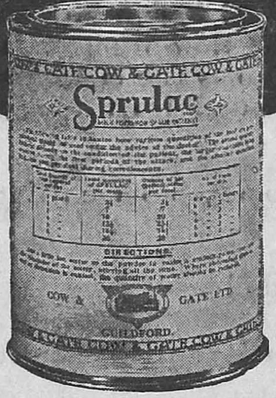
PUDUKOTTAH MEDICAL ASSOCIATION.

The monthly meeting of the Pudukottah Medical Association was held on Friday the 30th April '37 at the General Hospital, Pudukottah, with Dr. M. G. Ramachandra Rao, Chief Medical and Sanitary Officer, in the chair. A case note on acute appendicitis was read. Dr. N. C. Subramaniam, Honorary Assistant Surgeon, Tuberculosis Section, Headquarters Hospital, Trichy, delivered a lecture on 'Recent Advances in the Treatment of Pulmonary Tuberculosis.' There was also a demonstration about artificial pneumothorax.

MALABAR DISTRICT MEDICAL ASSOCIATION.

A meeting of the Malabar District Medical Association was held on 9th May '37 at the Government Headquarters Hospital with Capt. N. Navaneetha Krishnan, District Medical Officer, in the chair. The resolution of the Managing Committee of the Association regarding the speech alleged to have been made by Dr. Ramadas, the Assistant Surgeon, at the Government Headquarters Hospital, against the Indian District Medical Officers was taken up., After some discussion, a suggestion was made to drop the same but the majority being against, it was resolved that the above resolution may be sent back to the Managing Committee for reconsideration.

DIETETIC TREATMENT OF SPRUE



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Dr. C. K. Menon, read a paper on "Obscure fevers of children." This was followed by a discussion in which the members took part. The meeting then came to a close.

EAST GODAVARI DISTRICT MEDICAL ASSOCIATION.

A meeting of the East Godavari District Medical Association was held on 22nd May '37 in the City Middle School Hall with Dr. Allam Sahib (Assistant Civil Surgeon, Rajahmundry) in the chair.

Dr. Yerram Raju of the local Government Hospital demonstrated some interesting cases of liver enlargement and its treatment.

Dr. Satyanarayana of the local Central Jail read a paper on dysentery.

Dr. I. Joga Rao of Samalkota gave his experiences of treatment of eclampsia after delivery. A discussion on the differential diagnosis of uraemiccoma and eclampsia was held. The meeting terminated at 8 p.m. with a dinner.

RAMNAD DISTRICT MEDICAL ASSOCIATION.

The inaugural meeting for the year was heldat S. M. S. High School, Karaikudi on Saturday the 22nd May, 1937 with Captain B. Dayananda Rao, A. I. R. O., the President of the Association in the chair. There were 18 members present. Messrs F. Hoffmann La-Roche & Co. Ltd. Co. Basle, Switzerland represented by Dr. R. L. Dutt entertained the members to Tea.

In his opening speech the Chairman invited the members to meet at Ramnad at the earliest opportunity. In case the proposed joint meeting of the Madura-Ramnad Associations is not to take place at Madura in June, the next meeting was proposed to be held at Ramnad on the 19th June, 1937. The minutes of the last meeting (Seventh Annual Gathering) was read by the secretary and adopted.

The following resolution was moved from the chair and carried: " Proposed that Rao Bahadur S. Padmanabha Sarma and Rao Saheb A. Narayana Menon be congratulated on the distinction bestowed by the Government in the Coronation Honours and the secretary be authorised to communicate this resolution to the individuals."

The chairman read a paper on " Anaemias of Pregnancy." The incidence of this condition was found relative to poor quality of food and deficiency of vitamins. In the discussion it was urged that the Government, Local Board & Municipal authorities should be requested to take steps to abolish rice mills and introduce hand pounded rice.

The Secretary announced the meeting of the Mission Medical Conference at Kodaikanal on the 27th, 28th & 29th instant and requested the members to attend it. With the vote of thanks the meeting terminated.

ASSOCIATION OF MEDICAL LICENTIATES.

At a meeting of the Medical Licentiates of Ooty, Coonoor and suburbs, held on 23rd May '37 Dr. D. V. Venkappa, Provincial Secretary of the All-India Medical Licentaties Association, addressed them on the necessity of forming a branch in the Nilgiris.

Dr. Venkappa spoke about the origin and activities of the All-India organisation and said that the licentiates who formed the bulk of the profession in India should strengthen it with a view to improving their status and bringing about uniformity in their qualifications. He touched about the All-India Medical Council and stressed the necessity of including the licentiates in its purview.

Members present participated in the discussions and Drs. A. L. Meghanathan and C. N. Narayan wished for a general body meeting of the licentiates all over the hills, to elect office-bearers and transact other business.

With a vote of thanks the members dispersed.

MADURA MEDICAL ASSOCIATION.

A meeting of the members of the Madura Medical Association was held at "Salem House", Sokkikulam, on Wednesday the 26th May '37 under the presidency of Rao Bahadur S. Padmanabha Sarma, District Medical Officer. A large gathering of medical prctitioners was present. Dr. A. P. Pillai, Secretary of the Marriage Hygiene and Eugenic Society of Bombay, who is on a tour of South India to demonstrate to medical practitioners various up-to-date methods of birth control was present on the occasion and gave a lecture on birth control, explaining the mode of employing the appliances. Cinema films on the same topic were also exhibited to the audience.

After dinner at 9 p.m., the gathering dispersed.

KODAIKANAL MISSIONARY UNION.

A Medical Conference was held on the 27th instant in the premises of the Kodaikanal Missionary Union and it concluded. There was a large attendance. Dr. West of Parlakimedi (Orissa) presided.

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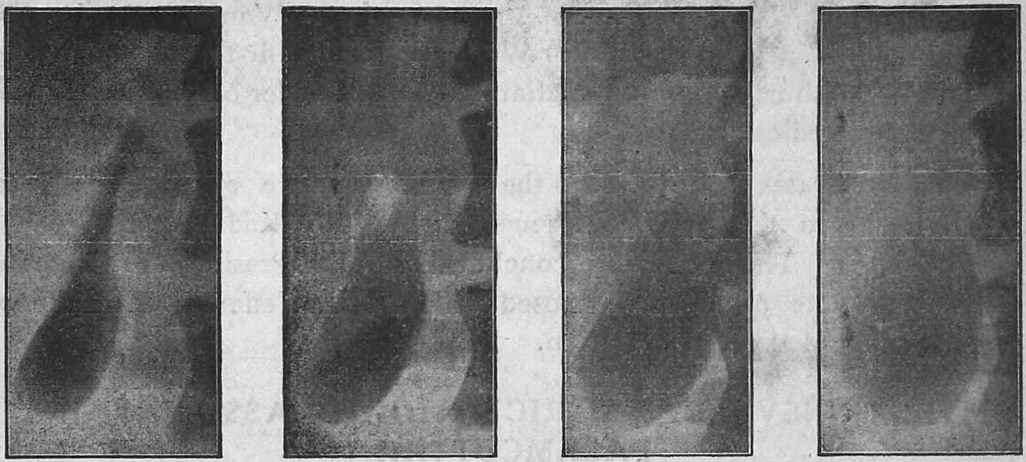

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JOURNAL.

The proceedings commenced with a devotional address by Dr. Paul Harrison of the Arabic Medical Mission followed by a brief speech of the President welcoming the delegates. A report of the Van Allen Hospital, Kodaikanal, was presented by Dr. Wilder and at the first day's session Rao Bahadur A. Lakshmanaswami Mudaliar and Dr. Ysander of Tirupattur spoke on subjects of medical interest.

The delegates and visitors to the Conference were entertained yesterday afternoon to tea by Dr. Chone Oliver at the Kodaikanal Missionary Union premises. The Conference concluded with the President's concluding remarks and vote of thanks proposed by Dr. (Miss) Jefferson of the Vellore Medical School Medical Association.

THE TINNEVELLY DISTRICT MEDICAL ASSOCIATION, PALAMCOTTAH.

(*Affiliated to the Indian Medical Association*).

The Tinnevelly District Medical Association held its monthly meeting at Palamcottah on Saturday the 29th of May 1937, in the premises of the St. John's College. Members numbering 62 including 3 women doctors were present. Lt. Cl. T. S. Shastry I. M. S. presided.

The Secretary read the minutes of the last monthly meeting, held at Tiruchendur on Saturday the 24th of April 1937, which were passed. The Secretary read the Code of Medical Ethics for the information of the members of the Association.

Dr. M. Shenbagam Pillai of Sivagiri, read out the notes of a case of Calculus in a female urethra—a rare case.

Dr. P. S. Srinivasan, L.M.P., of the Government Headquarters Hospital, Palamcottah, read out clinical notes on the following interesting cases.

1. A Case of Hydro-pyo-Nephrosis.
2. A Case of Parotid Tumour (right cheek).
3. A Case of Osteomyelitis. (Prontosil Treatment).
4. A Case of Cancer Stomach.
5. A Case of large Goitre.

The above cases were fully discussed by the members. Thereafter, the President, brought the meeting to a close by his remarks of each case and summed up the salient and important features of all cases. He thanked the College Authorities for placing the College Hall, at the disposal of the Tinnevelly District Medical Association for holding the meeting.